STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005009	A. BUILDING: _____ B. WING _____	06/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK MEMORIAL HOSPITAL	1220 MISSOURI AVE JEFFERSONVILLE, IN 47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the State investigation of a complaint. State complaint: IN00169483 Unsubstantiated; Lack of sufficient evidence Date of Survey: 06-15-15 Facility Number: 005009 Clark Memorial Hospital is in compliance with 410 IAC 15-1.5-6, Nursing services, 410 IAC 15-1.5-8, Physical environment, maintenance, and environmental services and 410 IAC 15-1.6.9, Other services, Hospital Licensure Rules. QA: cjl 07/02/15	S 000		